

## Policy Option: Community Health Record Expansion to Rural Environment

**Description:** Refine the model used in the Sedgwick County Community Health Record (CHR) pilot project and expand it to a rural health environment.

**Background:** Nearly two years ago, the State of Kansas implemented a pilot project engaging select managed care organizations and an information technology company to deploy community health record (CHR) technology to Medicaid managed care providers in Sedgwick County. The health record is built on administrative claims data and provides clinicians electronic access to claimed medical visits, procedures, diagnoses, medications, demographics, allergies and sensitivities, immunizations, vital signs, and lead screening and health maintenance data (includes Early and Periodic Screening, Diagnosis and Treatment [EPSDT] status).

The record also contains an e-Prescribing solution that enhances the clinician's workflow, reduces the risk of medication error caused by inadequate or unavailable patient information, and increases safety and health outcomes associated with prescription generation. This component provides a drug interaction and contraindication tool as well. The prescriber may access formulary information and has the capacity to submit prescriptions to pharmacies electronically. The pilot CHR also recently linked information from beneficiaries participating in the Enhanced Care Management pilot program.

The goal of the CHR pilot was to assess the value that health information exchange (HIE) could offer to Medicaid providers and beneficiaries. The health policy literature on Health Information Exchange suggests that "patients and providers most likely have the most to gain. Organizations such as regulatory agencies, research institutions, and others not considered here could benefit from aggregate information about care. However, those who depend in subtle ways on redundancy and excess could find such change costly"<sup>1</sup>.

Pilot statistics since the project's inception (February 2006)

- The CHR was limited to 20 provider sites throughout Sedgwick County and now includes 500 trained users.
- Measures collected by the vendor included
  - Patient Searches - 18,000 (includes front-desk users)
  - Chart Opens - 14,000
  - Completed Kan-Be-Healthy (EPSDT) Screening Forms - 1,100
  - E-Prescribing - 630 Scripts (88 trained users, 30 active users)
- 50% of the sites utilized the e-prescribing component
- 5,205 unduplicated beneficiaries' records were accessed by the 215 CHR providers in Sedgwick County in 2006

An independent evaluation of the CHR varied considerably by site (resource document in board binder). The evaluation recommends an expansion of the CHR to additional sites, incentives to clinicians to use the CHR, and specific targeting to sites like family practice and primary care clinics that perceived the most benefit from CHR and the e-prescribing tool. The independent physician end-user survey data was very positive.

Distinct from this pilot but built on the same CHR platform, the State Employee Health Benefit Plan currently is initiating participation in an employer-based community health record in the Kansas City area, which is home to about 11,000 state employees. The vendor and system features will mimic those available in the CHR, with the addition of consumer access to their own medical information.

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<sup>1</sup> Jan Walker, Eric Pan, Douglas Johnston, Julia Adler-Milstein, David W. Bates, and Blackford Middleton (2005). The Value Of Health Care Information Exchange And Interoperability. Health Affairs. January.

**Population Served:** Medicaid beneficiaries and providers in Sedgwick County and an additional rural county, yet to be determined.

**Costs:** The costs of expanding the pilot and enhancing the services are dependent upon the extent of program enhancements. Please see Board Action below.

**Considerations:** The Sedgwick County CHR project was launched in February 2006 and an initial evaluation was done in July 2007. That evaluation suggested some improvements to the program as well as recommending that the CHR program be expanded to additional sites. The initial feedback on the program was encouraging and has high potential to be a valuable tool for providers delivering services to all Medicaid/Healthwave and State Employee Health Plan enrollees. Before a decision to adopt the CHR program statewide, midcourse modifications (i.e. inclusion of additional data sources) to improve the pilot project CHR should be made and the pilot CHR should be tested in a rural environment. In addition a process for statewide expansion should be developed with attention to the recommendations of the Controlled Substance Task Force related to e-prescribing and the feasibility of including Medicaid/Healthwave and State Employee Health Plan enrollees examined.

**Staff Recommendation:** Request funding as an enhancement for FY 2009 to refine the model CHR, expand the utilization to a rural health environment. Per the suggestion at the August 2007 Board meeting, link the CHR to Enhanced Care Management program, and design the process and evaluate the feasibility of inclusion of Medicaid/Healthwave and State Employee Health Plan enrollees as part of health reform (see separate document on health reform, "Paying for a Primary Care Medical Home).

**Board Action:** On August 20, the KHPA Board directed staff to divide this proposal into two options:

Option A - This would continue the Sedgwick County CHR pilot project through FY 2009 as well as expand to CHR to additional users (limit to no more than twenty additional sites). This option would require no additional funding and the appropriated amount, \$250,000, remains in the base budget from FY 2008 to FY 2009. However, the contract with Cerner Corporation would need to be renewed to continue through FY 2009.

Option B - This would expand the use of the CHR in Sedgwick County (limit to no more than twenty additional sites) as well as in a designated rural community, including a more dispersed population and other health providers such as critical access hospitals, small clinics, independent pharmacies, and rural health Clinics. The additional pilot project should operate in the same area as the expanded Enhanced Care Management pilot project. This would test the efficacy of both the care management and interoperable health record model to improve the quality of care and health outcomes. This option would cost \$350,000. \$250,000 remains in the base budget; therefore, this option would require an additional \$100,000.

**Revised Staff Recommendation:** Staff recommendation is Option B.

**Final Board Action:**